

Orthopaedic Associates of Green Bay, S.C.
1630 Commanche Avenue • Suite 101 • Green Bay, Wisconsin 54313
(920) 468-0246 • Fax: (920) 432-9309
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION
PLEASE FILL OUT COMPLETELY

Patient Name: _____ D.O.B. _____

The Individual or organization who is releasing the medical information:

Name: _____

Street: _____

City: _____ State: _____ Zip Code: _____

The Individual or organization who is receiving the medical information:

Name: **ORTHOPAEDIC ASSOCIATES OF GREEN BAY**

Street: **1630 COMMANCHE AVENUE, SUITE 101**

City: **GREEN BAY** State: **WI** Zip Code: **54313**

Type of information released: _____

X-ray Films: _____ (Yes) _____ (No)

Purpose for release of medical records: _____

Effective Date of Release: _____ **Termination Date Release:** _____

Right to inspect or copy the information disclosed: I understand that I have a right to inspect or copy the information used or disclosed. I can contact Orthopadeic Associates of Green Bay's Privacy Officer.

I AUTHORIZE THE USE OR DISCLOSURE OF THE ABOVE NAMED INDIVIDUALS HEALTH INFORMATION AS DISCRIBED ABOVE. I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION.

***PATIENT NAME:** _____

***DATE:** _____